CONSENT

I have read the attached patient information and this consent form regarding influenza and the inactivated influenza vaccine. I have had the opportunity to ask questions and they have been answered to my satisfaction. I understand the benefits and risks of immunization with the inactivated influenza vaccine and request that the 2013-2014 influenza vaccine be administered to me.

WARNINGS:

You should **NOT** receive the vaccine without consulting your Primary Care Physician if you fall into the following categories. Please **check** any that apply to the person being vaccinated:

- ☐ Child less than 6 months of age.
- ☐ Have an allergy to eggs.
- ☐ Are currently ill with an acute respiratory or febrile infection; vaccination should be delayed until full recovery
- ☐ Have a severe allergy to any vaccine component, namely Thimerosal or gelatin (found in some vaccine products)
- ☐ Have had an *anaphylactic reaction* to Latex (Latex may be found in the rubber tip of pre-filled syringe doses of the flu vaccine)
- ☐ If you have had a severe reaction after a previous dose of influenza vaccine.
- ☐ Have either an active or past history of a neurological condition, in particular, Guillain-Barre Syndrome (GBS), especially if contracted within 6 weeks of getting a previous flu shot.

☐ **I am a health center patient**

_____ _____

Print Patient Name **Date of Birth**

_____

Address

_____ _____

Signature **Date**

(For Official Use Only)

Manufacturer Name: **Novartis Fluvirin** **Lot Number:** 1309601 **Exp. Date:** **04/2014**

VIS Title: **Inactivated Influenza Vaccine** **VIS DATE:** **7/26/13**

Injection Site (on body): **L** **R** **deltoid**

Health Center Name/Address: **Medpoint Health Center 588 Fortress Blvd. Murfreesboro, TN 37128**

Name of Vaccine Administrator: _____

Signature of Vaccine Administrator: _____ **Date:** _____

RETAIN THIS FORM IN PATIENT'S MEDICAL RECORD

Orig:8/08
Rev: 9/09,8/10, 9/11, 9/12, 8/13

take care health systems